TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 128
VETERANS HEALTH INSURANCE PROGRAM

SUBPART A: GENERAL PROVISIONS

Section

SUBPART B: GENERAL ELIGIBILITY AND ENROLLMENT

Section

AUTHORITY: The Veterans' Health Insurance Program Act [330 ILCS 125]

SOURCE: Emergency rule adopted at 30 Ill. Reg. 15044, effective September 1, 2006, for a maximum of 150 days; adopted at 31 Ill. Reg. _____, effective January 28, 2007.

SUBPART A: GENERAL PROVISIONS

Section 128.100 General Description

This Part implements the Veterans' Health Insurance Program Act [330 ILCS 125] that authorizes the Department to administer a program to offer uninsured veterans in Illinois access to health benefits. The Department coordinates with the Illinois Department of Veterans' Affairs to assist veterans to apply for the program. Eligible veterans are not eligible for Veterans Administration Healthcare or other State-administered health benefits. The Department shall provide health benefits coverage to eligible veterans through purchasing or providing health care benefits. When cost-effective, the Department may offer veterans subsidies toward the cost of privately sponsored health insurance, including employer-sponsored health insurance.

Section 128.110 Definitions

For the purpose of this Part, the terms shall be defined as follows:

"Act" means the Veterans' Health Insurance Program Act [330 ILCS 125].

"Department" means the Department of Healthcare and Family Services and any successor agencies.

"DVA" means the Illinois Department of Veterans Affairs.

"Family" means the veteran applying for the program and the following individuals living with the veteran who are counted in determining eligibility:

The spouse of the veteran

Children under 19 years of age of the veteran or the veteran's spouse

If the veteran or the spouse is pregnant, the unborn children.

"Federal Poverty Level" means the federal poverty income guidelines as established by the federal Department of Health and Human Services and published in the Federal Register.

"Health Insurance" means health insurance coverage as defined in 215 ILCS 105/2.

"Practitioner" means a physician (including a hospital billing a physician office visit), osteopath, podiatrist, optometrist, chiropractor, advanced practice nurse, Federally Qualified Health Center, Rural Health Clinic or Encounter Rate Clinic.

"Program" means the program created under the Veterans' Health Insurance Program Act and this Part, commonly called Veterans Care.

"Resident" means an individual who has an Illinois residence, as provided in Section 5-3 of the Illinois Public Aid Code.

"Uninsured" means the person is not covered by group or individual health insurance that provides coverage for hospitalization and physician visits.

"Veteran" means an individual who served for at least 180 consecutive days after initial training in any branch of the U.S. military including the Reserves and

National Guard. The veteran must not be currently on active duty in the U.S. military.

"Veterans Administration Geographic Means Test" means the income guidelines established by the U.S. Veterans Administration annually by county and published in the Federal Register for determining eligibility for Veterans Administration healthcare.

"Veterans Administration Healthcare" means any of the health programs or services provided or administered by the U.S. Department of Veterans Affairs.

"Veterans Care" means the common name for this program under the Act.

SUBPART B: GENERAL ELIGIBILITY AND ENROLLMENT

Section 128.200 Eligibility

A veteran may be eligible for Veterans Care provided that all of the following eligibility criteria are met:

a) The veteran is not eligible for Veterans Administration healthcare, medical assistance under the Public Aid Code or benefits, including rebates, under the Children's Health Insurance Program Act;

b) The veteran was not dishonorably discharged;

c) The veteran is a resident of the State of Illinois;

d) The veteran is at least 19 and is no more than 64 years of age; and

e) The veteran meets one of the following:

1) The veteran has been uninsured for at least six months;

2) The veteran lost health insurance when the veteran’s or the veteran’s spouse’s job ended within six months prior to applying under this Part;

3) The veteran has exhausted the life-time benefit limit of his or her health insurance within six months prior to applying under this Part;

4) The veteran’s health insurance is purchased under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA);

5) The veteran was disenrolled for medical assistance under the Public Aid Code or benefits, including rebates under the Children’s Health Insurance Program Act, within six months prior to applying under this Part;

6) The veteran has health insurance provided by the veteran’s spouse but the veteran is unable to access such health insurance benefits;

7) The veteran has post-active duty related TRICARE healthcare coverage.

Section 128.210 Eligibility Exclusions and Terminations

a) A veteran shall not be determined eligible for Veterans Care if:

1) The veteran is an inmate of a public institution.

2) The veteran is a resident of a nursing facility.

b) A veteran's coverage under the program shall be terminated if the veteran:

1) Loses his or her Illinois residency.

2) Attains 65 years of age.

3) Becomes enrolled in Veterans Administration healthcare, medical assistance under the Public Aid Code or health benefits including rebates under the Children’s Health Insurance Program Act.

4) Meets the provisions of subsection (a) of this Section.

5) Fails to pay the premium as specified in Section 128.330.

6) Fails to report to the Department changes that affect eligibility for the program.

7) Asks the Department to terminate the coverage.

8) Is no longer eligible based on any other applicable State or federal law or regulation.

9) Failed to provide eligibility information that was truthful and accurate to the best of the veteran's knowledge and belief and that affected the veteran’s eligibility.

10) Was incorrectly determined eligible.

11) Fails to complete the redetermination of eligibility within the required timeframes or provide proof of on-going eligibility.

12) Becomes covered by other health insurance.

c) Following termination of a veteran’s coverage under the program, the following action is required before the veteran can be re-enrolled:

1) A new application must be completed and the veteran must be determined otherwise eligible.

2) There must be full payment of premiums due under this Part for periods in which a premium was owed and not paid.

3) If the termination was the result of non-payment of premiums, the veteran is ineligible for the program for three months, starting with the first month of cancellation or termination from coverage, before becoming eligible for re-enrollment.

4) If there was an unpaid premium from a previous coverage period, the unpaid premium, in addition to the first month's premium, must be paid before new coverage may begin.

Section 128.220 Application Process

a) Veterans apply for the program by submitting the Veterans Care application to the Department, or through one of the DVA's Veterans Service Offices, through the Veterans Assistance Commission serving the veteran's community, or through a U.S. Veterans Administration facility in Illinois. The Department may designate additional entities that may assist veterans to submit applications.

b) The application must meet all requirements found at 89 Ill. Adm. Code 110.10, including provisions regarding who may apply on behalf of the veteran.

c) Applicants are obligated to provide truthful and accurate information for determining eligibility and to promptly report any change in information provided on the application.

d) The Department may stop taking applications if that is necessary to maintain the cost of the program within the available funding.

Section 128.230 Determination of Monthly Countable Income

a) The earned and unearned income of the following persons shall be counted when determining eligibility, except as specified in subsections (b), and (c) of this Section.

1) Income of the veteran;

2) Income of the veteran's spouse;

3) Unearned income of a dependent child under the age of 18 years who is included in the income standard as set forth at 89 Ill. Adm. Code 120.20 because it is to the advantage of the veteran.

b) Monthly unearned income shall be counted as described at 89 Ill. Adm. Code 120.330 through 120.345 and Sections 120.350, 120.355, 120.371 and 120.376. However, 89 Ill. Adm. Code 120.335(a) shall not apply.

c) Monthly earned income shall be considered as described at 89 Ill. Adm. Code 120.360, 120.361, 120.371, 120.372, 120.373 and 120.375.

Section 128.240 Eligibility Determination and Enrollment Process

a) The applicant's military discharge status, time spent in active duty, health insurance status and eligibility for Veterans Administration healthcare will be reviewed first.

b) For the purpose of determining eligibility under this Part, applicants who are not found ineligible under subsection (a) of this Section will be screened for eligibility for medical assistance under the Public Aid Code or health benefits, including rebates, under the Children's Health Insurance Program Act. Veterans who are likely to be eligible for these other programs will be directed to apply for them. Veterans may be enrolled under this Part while an application for coverage under another program is pending.

c) If the monthly countable income is below the Veterans Care income standard, the application will be approved if all other factors of eligibility are met. The Veterans Care income standard is 25 percent of the Federal Poverty Level plus the Veterans Administration Geographic Means Test threshold. If fewer than 1,500 veterans are enrolled in the program by February 1, 2007, the Department may determine, at its sole discretion, that resources are available to raise this standard to 50 percent of the Federal Poverty Level plus the Veterans Administration Geographic Means Test threshold effective March 1, 2007.

1) If the veteran's income is equal to or less than 25 percent of the Federal Poverty Level plus the Veterans Administration Geographic Means Test threshold, the veteran shall be enrolled in Veterans Care Premium Level I.

2) If the veteran's income is more than 25 percent of the Federal Poverty Level plus the Veterans Administration Geographic Means Test threshold and equal to or less than 50 percent of the Federal Poverty Level plus the Veterans Administration Geographic Means Test threshold, the veteran shall be enrolled in Veterans Care Premium Level II.

d) Applicants will be notified, in writing, regarding the outcome of their eligibility determination.

e) Eligibility determinations for the program made by the 10^{th} day of a month will be effective the first day of the following month. Eligibility determinations for the program made after the 10^{th} day of a month will be effective no later than the first day of the second month following that determination.

f) The duration of eligibility for the program will be 12 months unless one of the

events described in Section 128.210(b) occurs or the Department shortens the enrollment period to maintain program spending within available funding.

g) Veterans may obtain backdated medical coverage for the month of application plus up to three months prior to the month of application but no earlier than the beginning of the program on September 1, 2006. This coverage shall be subject to the veteran paying the premiums for the months of backdated coverage requested. The veteran may choose the month for which backdated coverage will begin. Backdated months of coverage shall be consecutive beginning with the initial month of backdated coverage requested.

h) At the sole discretion of the Department, the Department may reduce the income threshold established in subsection (c) of this Section if necessary to keep the cost of the program within available funding.

Section 128.250 Appeals

a) Any person who applies for or receives benefits under the program shall have the right to appeal any of the following actions:

1) Refusal to accept an application.

2) Denial of an application or cancellation at the redetermination of eligibility, including denial based on failure to meet one or more of the eligibility requirements specified in this Part. No eligibility exists during the appeal process. If the appeal is upheld, the veteran will have the opportunity to receive coverage back to the original application date including possible backdated months or the cancellation month. All premium and co-payment requirements shall apply to the retroactive period.

3) Termination of coverage based on failure to continue to meet one or more of the eligibility requirements specified in this Part. If the termination is not upheld on appeal, coverage under the Program shall be reinstated retroactive to the termination date. All premium and co-payment requirements shall apply to any retroactive period. The veteran may choose coverage for all or some of the months during the appeal process as long as the retroactive months are consecutive to the new initial month of regular eligibility.

4) Determination of the amount of the premium or co-payments required. Any premium or co-payment requirements shall remain in force during the appeal process.

5) Individuals or their representatives do not have the right to appeal Department decisions necessary to keep the cost of the program within the annual appropriations, such as a Department decision to:

A) cease accepting applications pursuant to Section 128.200(d).

B) increase premium levels for all individuals within an income range.

C) require more frequent redeterminations of eligibility.

D) increase the income standard.

b) In addition to the actions that are appealable under subsection (a) of this Section, individuals shall have the right to appeal any of the following actions:

1) Termination of coverage due to non-payment of the required premium.

2) Denial of payment for a medical service or item that requires prior approval.

3) Decision granting prior approval for a lesser or different medical service or item than was originally requested.

c) Individuals may initiate the appeal process by:

1) Filing a written, signed request for a hearing directed to the Department's Bureau of Administrative Hearings;

2) Calling a toll free telephone number designated by the Department.

d) The request for a hearing may be filed by the individual affected by the action or by the individual's authorized representative.

e) For purposes of initiating the appeal process, a copy of a written, signed request for a hearing is considered the same as the original written, signed request.

f) The request for a hearing must be filed no later than 60 days after notice of the appealable action has been given.

g) The provisions of Subpart A of the Department's administrative rules at 89 Ill. Adm. Code 104, Practice in Administrative Hearings, shall govern the handling of appeals and the conduct of hearings under the Program.

h) An individual can, prior to a decision being rendered on the appeal, reapply for the Program.

Section 128.260 Renewals of Eligibility

a) Eligibility shall be reviewed at least annually.

b) Prior to the eligibility period ending, and in sufficient time for the veteran to respond to the Department's request for information, the Department or its designee will send an annual renewal notice to the veteran.

c) Renewals shall be subject to all eligibility requirements and exclusions set forth in Sections 128.200 and 128.210(a).

d) The Department may require renewal of eligibility more frequently than annually if necessary to keep spending within available funding.

Section 128.300 Covered Services

Covered health care services shall be the same as covered services for adults described in the State's approved plan under Title XIX of the Social Security Act, except as provided in Section 128.310.

Section 128.310 Service Exclusions

The following health care services shall not be covered under this Part.

a) Non-emergency medical transportation.

b) Nursing facility services.

Section 128.320 Co-payments and Cost Sharing

a) Co-payments or cost sharing may be charged for services provided to a veteran by a health care provider as described in subsection (b), except for practitioner visits scheduled for family planning services.

b) Co-payment and cost sharing requirements are as follows:

1) Practitioner office visits, $15;

2) Dental visits, $15;

3) Inpatient hospitalizations, $150 per hospital stay;

4) Hospital or Ambulatory Surgical Treatment Center outpatient encounters with a payable service on the Ambulatory Procedure List as set forth at 89 Ill. Adm. Code 148.140(b), 10 percent of the Department rate as set forth in Section 128.350(c);

5) Hospital Emergency Visits, $50;

6) Prescription drugs, $6 for a 1- to 30-day supply of generic drugs or $14 for a 1- to 30-day supply of brand name drugs.

c) Providers are responsible for collecting co-payments.

d) Providers may elect not to charge co-payments. If co-payments are charged, the co-payment may not exceed the amounts established in this Section.

Section 128.330 Premium Requirements

a) Veterans enrolled in Veterans Care must pay a monthly premium as follows:

1) Veterans Care Premium Level I: $40 per month.

2) Veterans Care Premium Level II: $70 per month.

b) No premium is charged for the first two months of prospective eligibility for first-time participants whose initial month of coverage, not counting backdated months, begins prior to January 1, 2008.

c) Premiums are billed by and payable to the Department, or its authorized agent, on a monthly basis.

d) The premium due date is the 20th day of the month preceding the month of coverage.

e) The premium may increase during the eligibility period if the Department makes a decision to increase premiums to keep the Program costs within available funding.

f) Premiums for backdated months must be received by the 90th day after the date of eligibility determination. Coverage for backdated months is not provided if the payment is not received by the due date.

Section 128.340 Non-payment of Premium

a) For initial coverage, veterans will have a grace period through the end of the month preceding the third month of coverage to pay the premium. For subsequent months, veterans will have a grace period of one month following the month in which the premium was due to pay the premium.

b) Failure to pay the full monthly premium by the last day of the grace period will result in termination of coverage.

c) Partial premium payments will not be refunded.

d) When termination of coverage is recorded by the 10th day of the month, it will be effective the first day of the following month. When termination of coverage is recorded after the 10th day of the month, it will be effective no later than the first day of the second month following.

Section 128.350 Provider Reimbursement

a) Provider participation under this Part shall be subject to enrollment with and approval by the Department to provide health care under 89 Ill. Adm. Code 140.11 and 140.12.

b) Provider participation under this Part shall be voluntary.

c) Providers under this Part shall be reimbursed in accordance with the established rates of the Department or other appropriate State agency as set forth in 89 Ill. Adm. Code 140, 143, 144, 148, 149, 152, and 153; 52 Ill. Adm. Code 132; and 77 Ill. Adm. Code 2090 less co-payments or cost sharing as specified in Section 128.320 regardless of whether the patient share is collected.

d) Providers under this Part shall be prohibited from billing veterans covered under Veterans Care for any difference between the charge amount and the amount paid by the Department other than the co-payment amounts specified in Section 128.320.

e) Providers shall be responsible for refunding to the veteran co-payments collected in excess of the amounts permitted by this Part.